Congressman Adler requests report from the VA Secretary on steps taken to protect veterans

Washington DC - Congressman John Adler, a member of the House Veterans Affairs Committee, called on the Department of Veterans Affairs (VA) today to provide Congress with a report on the growing number of medical mistakes found at the Philadelphia VA and an update on the steps being taken to increase oversight throughout the agency. In a letter sent to Secretary Eric Shinseki, Congressman Adler said the reform measures currently being discussed by the VA do not adequately address the lack of oversight and supervision at the federal agency.

"Our veterans have waited long enough for answers about the growing cases of medical mistreatment at the Philadelphia VA," Congressman John Adler said. "In the coming weeks, I am expecting a full report from the VA on what happened at our local hospital, and what is being done to make sure it does not happen again. I have not heard the VA put forward a responsible plan to increase oversight and accountability at the agency and VA hospitals across the country."

On July 22, the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations held their first hearing on the suspended brachytherapy program at the Philadelphia VA Hospital, as well as to evaluate the VA's broader brachytherapy program safety standards. Since that hearing, the VA has reported six additional cases of mistreatment previously reported from the Philadelphia VA's brachytherapy program.

Congressman Adler called today for a full and complete accounting of the errors that occurred in the Philadelphia VA's brachytherapy program. In addition, he requested a status update on the VA's progress in conducting a system wide evaluation and implementing measures to increase oversight and accountability at the agency. The complete text of the letter sent to Secretary Shinseki follows.

The Philadelphia VA serves more than eight counties in New Jersey and Pennsylvania. Congressman Adler represents more than 60,000 veterans, including residents of Burlington and Camden County who seek medical treatment regularly at the Philadelphia VA Hospital.

August 25, 2009

The Honorable Eric K. Shinseki
Secretary, U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shinseki:

The House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations held a hearing on July 22, 2009, entitled, "Enforcement of the U.S. Department of Veterans Affairs Brachytherapy Program Safety Standards." This hearing was convened in an effort to evaluate the suspended brachytherapy program at the Philadelphia VA Hospital, which treated prostate cancer patients from 2002 until it was forced to close in June 2008, as well as to evaluate the Department of Veterans Affairs' (VA) broader brachytherapy program safety standards.

Since the date of that hearing, it has been reported that six (6) additional medical events (as that term is defined in NRC regulations) have been added to the number of medical events previously reported from the Philadelphia VA's brachytherapy program. These additions bring the total number of medical events discovered at the Philadelphia VA up to 98, which is an 86% failure rate for that brachytherapy program. It is frustrating to learn that more than a year after closing this program, the Philadelphia VA is still finding errors in the treatment it provided to our veterans. Please provide a full and complete accounting of the errors that occurred in the Philadelphia VA's brachytherapy program as soon as possible.

At the July 22nd hearing, several officials from your department testified and fielded questions from members of the committee. Among these officials was Joseph A. Williams, Assistant Deputy Under Secretary for Health for Operations and Management. In his opening statement to the committee, Mr. Williams outlined three (3) reform measures the VA will be implementing to ensure that the problems of the brachytherapy program in Philadelphia are not repeated elsewhere in the VA healthcare system.

The first measure would require the American College of Radiology (ACR) to conduct site surveys for each VA facility that performs brachytherapy. The second measure would require all VA medical facilities performing brachytherapy to develop, maintain, and implement written

procedures based on the American College of Radiology's Practice Guidelines for Transperineal Permanent Brachytherapy of Prostate Cancer and publications by the American Association of Physicists in Medicine. Lastly, Mr. Williams asserted that the VA has developed criteria for suspending and restarting brachytherapy programs. Please provide a status update on the implementation of these measures.

While the reform measures outlined by Mr. Williams are laudable goals and I look forward to their implementation, they do not address what I believe to be the biggest failure at the Philadelphia VA brachytherapy program: lack of oversight and supervision. First, the VA needs to increase its oversight and supervisory roles over the independent contractors it employs to ensure these contractors are acting in accordance with the standards and guidelines implemented throughout the VA Health System. One of the most glaring failures of the Philadelphia VA Medical Center was the lack of oversight provided over its independent contractors. In that vein, I encourage the VA to conduct a full evaluation of the methods it uses in contracting with private institutions for medical personnel throughout the country. I implore the VA to take a more active role in the supervision of these independent contractors. Please provide a status update on the VA's system wide implementation of a more stringent supervisory role over its independent contractors.

Additionally, the VA should increase its oversight and review of the low-volume programs, such as brachytherapy, in their medical facilities, to make sure that not one of our veterans is receiving substandard care. It is indisputable that if the Philadelphia VA's brachytherapy program had undergone independent peer review and was subjected to greater oversight and supervision, the substandard medical care we now know was administered would not have been allowed to continue for six years. I implore the VA to review all of its low volume programs to ensure that even the smallest programs serving our veterans are receiving the highest level of supervision and medical effectiveness. Please provide a status update on the VA's progress in conducting this system wide evaluation.

Thank you in advance for your attention to this very serious matter. As the only member of the House Committee on Veterans' Affairs from the Philadelphia area, I will continue to work diligently to ensure that the failures that occurred at the Philadelphia VA Medical Center are not repeated elsewhere in the VA Health System. I look forward to your response and to working with you in the future to ensure the highest quality of care for all of our veterans.
Sincerely,

John Adler

Member of Congress